kotak life

kotak General Insurance

ADD **HEALTH** TO YOUR **LIFE**

with one combi plan that secures you & your family!

INTRODUCING

Kotak 1+1 Health Maximiser

A Non-Linked, Non Participating,
Health Plus Life Combi Insurance Plan

A comprehensive health + life combi at an affordable premium

Kotak Health Maximiser

A Non-Linked, Non Participating, Health Plus Life Combi Insurance Plan

You strive to provide comfort, happiness, and security to your family and want to protect your own and your family's health and have a secured financial future for your loved ones, even when you are not around. Presenting **Kotak Health Maximiser** – a specially designed solution that offers a combination of Life and Health cover under a single plan. Now you can ensure that your loved ones are not only financially secured while you are not around, but also during your presence.

The plan provides for Hospitalization Benefits under the medical insurance policy provided by Kotak Mahindra General Insurance Company Limited. In the unfortunate event of death of the Proposer during the term, the beneficiary would receive Death Benefit as per plan option selected under the life insurance cover provided by Kotak Mahindra Life Insurance Company Limited.

Key Features

- Life + Health coverage under one plan
- **Avail up to 12 Optional Benefits** for a comprehensive coverage
- Flexibility to add **Riders** to enhance protection
- **Hassle Free Issuance** with Minimal Documentation
- **Avail 5% Combi Discount*** on 1st Year Premium

*You are eligible for 5% premium discount on the first year life and health premium. However, for health cover the Combi Discount shall be applicable as long as the Life & Health cover are renewed together. There is no renewal discount on Life Cover.

Key features under Life & Health Cover

Life

- Provide **financial protection** to you and your family at an affordable cost
- Flexibility to choose your **policy** and **premium payment** terms
- **Preferred premium rates** for female lives
- **Flexibility** to avail comprehensive coverage through multiple **Riders**
- Avail **Tax Benefit** under Section 80C and 10 (10D) as per current tax laws

Key features under Life & Health Cover

Health

- Cover your expenses incurred during **inpatient hospitalization** and on 405 listed day care procedures
- **Restore** your sum insured once in a policy year automatically, in case you exhaust it
- Customize your health cover with a choice of **7 plan options**
- Enhance your health cover through **cumulative bonus**
- Avail **tax benefit** under Section 80D as per current tax laws
- Option to avail health cover on **individual** or **family floater** basis
- **Cashless facility** in over **7800+** hospitals across the country
- **Lifelong coverage** for you and/or your loved ones on continuous renewal and irrespective of any claims under the policy

1 Life Cover

You may select your Sum Insured as per your convenience subject to a maximum of ₹ 24,99,999. Once the policy is issued, the Sum Insured cannot be changed during the policy term. The Sum Insured shall only be applicable for the Proposer* of the plan.

*Note: The Proposer shall also be the Life Insured under Life Cover and Life Insured 1 under Health Cover.

1.a. Death Benefit under Life Cover[1T&C]:

In case of the unfortunate event of death of the Proposer during the policy term, the Death Benefit payable shall be Sum Insured opted for under Life Cover. In case any balance premium for the policy year was left un-paid due to death of the Proposer, the same shall be deducted from the Sum Insured before the pay-out is made to the beneficiary.

The benefit shall be paid out as lump-sum. Once the benefit is paid out, the Life Cover shall cease and the Health Cover may continue for other members, as long as the premiums are being paid.

1.b. Tax Benefit under Life Cover:

You may avail of tax benefits under Section 80C and Section 10(10D) of Income Tax Act, 1961 subject to conditions as specified in those sections. Tax benefits are subject to change as per tax laws. You are advised to consult your Tax Advisor for details. Goods and Services Tax and Cess, as applicable shall be levied over and above premium amount shown here as per applicable tax laws.

1.c. Riders:

You may avail of the following rider benefits by paying an additional premium:

- **Kotak Accidental Death Benefit Rider (ADB / UIN: 107B001V03):** Lump sum benefit paid on accidental death.
- **Kotak Permanent Disability Benefit Rider (PDB / UIN: 107B002V03):** Instalments paid on admission of a claim on becoming disabled due to accident.
- **Kotak Critical Illness Plus Benefit Rider (CIP / UIN:107B020V01):** Rider Sum Insured shall be payable on admission of a claim on any one of the 37 covered critical illness, subject to terms and conditions, definitions and specific exclusions.

1.d. Plan Conversion Option:

You may convert your Kotak Term Plan to any other plan offered by Kotak Life Insurance (except for another term plan) provided there are at least 5 years remaining before the cover ceases.

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2 Health Cover

You have the option to choose any one of the **7 Plan Options** under this product. Once you have opted the plan option, you may choose the Health Sum Insured basis on your requirement on individual or family floater basis. The Proposer (also the Life Insured 1 under Health Cover) has to be covered under individual or family floater policy.

Plan Options	Sum Insured (in Lakhs)
Standard	2^ Lakhs
Advantage	3 / 4 / 5 / 7.5/ 10 Lakhs
Edge	5 / 7.5 / 10 / 15 / 20 Lakhs
Elite	10 / 15 / 20 / 25 Lakhs
Absolute	25 /50 /75 /100 / 150 /200 Lakhs
360	2^ / 3 / 4 / 5 / 7.5 / 10 / 15 / 20 / 25 / 50 / 75 / 100 / 150 / 200 Lakhs
Total	2^ / 3 / 4 / 5 / 7.5 / 10 / 15 / 20 / 25 / 50 / 75 / 100 / 150 / 200 Lakhs

^2 Lakhs Sum Insured shall only be available for Individual Lives

2.a. Benefits applicable under Health Cover:

Your health cover shall depend on the Plan Option chosen by you. The benefits applicable under various Plan Options are explained below:

2 .b.i. Benefits under Health Cover:

	Standard	Advantage	Edge	Elite	Absolute	360	Total
In-patient Treatment	Upto Base Health Sum Insured						
Day Care Treatment	405 Named Day-care Surgeries & Procedures						
Pre-Hospitalization Medical Expenses	60 days				90 days	**For Sum Insured:** 2 - 20 lacs - 60 days 25 - 200 lacs - 90 days	
Post-Hospitalization Medical Expenses	90 days				180 days	**For Sum Insured:** 2 - 20 lacs - 90 days 25 - 200 lacs - 180 days	
Ambulance Cover	Upto INR 20,000 per year				Upto ₹ 50,000 per year	**For Sum Insured:** 2 - 20 lacs - Upto ₹ 20,000 per year 25 - 200 lacs - Upto ₹ 50,000 per year	
Organ Donor Cover	Up to Base Health Sum Insured						
Alternative Treatment	Upto Base Health Sum Insured						
Domiciliary Hospitalisation	Upto Base Health Sum Insured						
Restoration Benefit	Additional Sum Insured equivalent to Base Health Sum Insured						
Cumulative Bonus	10% of the Base Health Sum Insured, upto a max. of 50% for each claim free year; No reduction in case of claim		10% of the Base Health Sum Insured, upto a maximum of 100% for each claim free year; No reduction in case of claim			2 - 20 lakhs: 10% of the Base Health Sum Insured, upto a maximum of 50% for each claim free year; No reduction in case of claim 25 - 200 lakhs - 10% of the Base Health Sum Insured, upto a maximum of 100% for each claim free year; No reduction in case of claim	

2.b.ii. What is covered under above mentioned Benefits?

1. Inpatient Treatment:

In the event of any Insured Person being hospitalized during the policy term, the medical expenses incurred during hospitalization shall be payable for:

- Room Rent & Other Boarding charges;
- Anaesthesia, Blood, Oxygen and Blood Transfusion charges;
- Operation Theatre expenses, Inpatient Physiotherapy & Qualified Nurses' charges
- Medical Practitioner's fees including fees of specialists and anaesthetists
- Medicines, Drugs and other allowable consumables prescribed by the treating Medical Practitioner;
- Investigative tests or diagnostic procedures directly related to the injury or illness;
- Surgical appliances and Prosthetic Devices

Provided the hospitalisation is for a minimum and continuous period of 24 hours and is medically necessary and follows the written advice of a Medical Practitioner. For more details, please refer to the policy document.

2. Day Care Treatment

All procedures don't require 24 hours hospitalization and can be done within few hours because of technological advancement. Medical Expenses incurred in the event of any Insured Person's Day Care Treatment during the policy period, provided the same is medically necessary and follows the written advice of a Medical Practitioner shall be payable.

Further, the benefit shall only be payable for those Day Care Treatments which are listed in Annexure II of the Health Policy Document. The complete list of day care treatments covered is also available on www.kotakgeneral.com. Any treatment related to Out Patient Department shall not be cover under this benefit.

3. Pre-Hospitalization and Post-Hospitalization Medical Expenses

Not all diagnosis or tests happens once someone is hospitalized! Any expenses incurred for consultations, investigations and medicines by you for the illness or injury, during the policy period, due to which the Insured Person had been hospitalized or have undergone day care procedures shall be payable. The benefit shall be payable only if the expenses are related to the same illness / medical condition for which the Insured Person was either hospitalised or have undergone day care procedures. The benefit payable shall be based on the Health Plan Option chosen by you as mentioned in Section 2.b.i. For more details, kindly refer to Health Policy Document.

4. Ambulance Cover

Expenses incurred on availing ambulance services offered by a healthcare or ambulance service provider for any of the Insured Person covered under Health Cover shall be payable under the following scenarios:

For necessary transportation to the Hospital for treatment of an Illness or Injury following an Emergency	For necessary transportation from one hospital to another hospital for better facility due to lack of available/adequate treatment facilities at the existing Hospital	For necessary transportation from one hospital to diagnostic centre for advanced diagnostic where such facility is not available at the existing Hospital

The benefit payable shall depend upon the Health Plan Option chosen by you as mentioned in Section 2.b.i. For more details, kindly refer to health policy document.

5. Organ Donor Cover

Under this benefit, the in-patient hospitalisation medical expenses towards the donor for harvesting the organ shall be payable up to the limits of the Base Health Sum Insured (subject to availability) provided the organ donated is for the use of any of the Insured Person under the Health Cover, who has been asked to undergo an organ transplant on Medical Advice.

Any expenses towards the donor in respect of pre-hospitalization or post-hospitalization medical expenses or costs directly or indirectly associated to the acquisition of the organ or other medical treatment or complication in respect of the donor, consequent to harvesting or admission not compliant under the Transplantation of Human Organs Act, 1994 (as amended) shall not be covered. For more details, kindly refer to Health Policy Document.

6. Alternative Treatment

In the event of any of the Insured Person being admitted to Hospital (for AYUSH treatment) as an inpatient for the Alternative Treatment where the treatment is administered by a Medical Practitioner, then the medical expenses incurred on the Insured Person's Alternative Treatment during the policy period, following an Illness or Injury that occurs during the policy period up to the limits of the Health Sum Insured (subject to availability) shall be payable to you. For more details, kindly refer to Health Policy Document.

7. Domiciliary Hospitalisation

Under this benefit, medical expenses incurred, during the policy term, for an illness or injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances shall be payable up to the Health Sum Insured:

The Insured Person's condition did not allow a hospital transfer or a hospital bed was unavailable	The domiciliary hospitalisation is medically necessary and follows the written advice of a medical practitioner	The medical expenses incurred are reasonable and customary charges;	The Insured Person's domiciliary hospitalisation extends for at least 3 consecutive days

For more details, kindly refer to Health Policy Document.

8. Restoration Benefit

This is a unique benefit that automatically restores 100% of Base Health Sum Insured once in a policy year, in case Base Health Sum Insured along with Cumulative Bonus is insufficient due to previous claims. Restoration Benefit is over and above the Base Health Sum Insured. In case of accident related claims, restoration will be applicable from first claim onwards. In case of illness, this restored amount can be used for all future claims not related to the same illness for which a claim has been made for the same Insured Person.

Illustration - Base Sum Insured: 3 lacs

Claim Type	Claimed amount	Paid amount	Remarks
Claim 1: Accident	₹ 2 lacs	₹ 2 lacs	Base Sum Insured is paid
Claim 2: Cancer	₹ 2 lacs	₹ 2 lacs (₹ 1 Lac - Base Sum Insured & ₹ 1 Lac - Restoration Benefit)	Restoration Benefit will trigger as it's the 2nd claim and is unrelated and the Balance Health Sum Insured is insufficient.
Claim 3: Dengue	₹ 3 lacs	₹ 2 lacs (Restoration Benefit)	Restoration Benefit will trigger for unrelated illness. Balance Health Sum Insured under Restoration Benefit will be paid and the remaining claim amount will be borne by the Insured Person.
Claim 4: Heart Attack	₹ 1 lacs	-	Claim will be borne by the Insured Person as Base Health Sum Insured and Restoration Benefit amount has been utilised in the previous claims.

Note: All the claims mentioned in the illustration fall in the same policy year.

Please note that the Restoration Benefit is over and above the Base Health Sum Insured and shall be triggered only after the Base Health Sum Insured and Cumulative Bonus, if any have been completely exhausted in that year. Any restored sum insured which is not utilized in a policy year shall not be carried forward to any subsequent policy year. For more details, kindly refer to Health Policy Document.

9. Cumulative Bonus

For each claim free year, the health Sum Insured under this policy shall be increased by 10% p.a. subject to a maximum of either 50% or 100% based on the Health Plan Option chosen by you as mentioned in Section 2.a.i. Cumulative Bonus under a Family Floater Policy will be available only to those Insured Persons covered under Health Cover in the immediately completed policy year. For more details, kindly refer to Health Policy Document.

For example, where the Health Sum Insured is ₹10 Lakhs, in case no claim has been paid for a continuous period of 5 years, the health Sum Insured shall increase to ₹15 Lakhs without any extra premium.

2.b.iii. Other Inbuilt/ Optional Benefits under Health Cover:

The policy comes with a host of other covers which are either inbuilt or available as an optional cover (on payment of additional premium) depending on the plan chosen.

	Standard	Advantage	Edge	Elite	Absolute	360	Total
Hospital Daily Cash	₹500 per day		₹1,000 per day	₹1,500 per day	₹2,000 per day	**Optional Cover:** 2 - 20 lakhs - ₹1,000 per day 25 - 200 lakhs - ₹2,000 per day	
	Benefit shall be payable for a maximum of 10 days subject to minimum of 3 days of hospitalization is required						
Convalescence Benefit	₹10,000		₹15,000	₹20,000	₹25,000	**Optional Cover:** 2 - 20 lakhs - ₹15,000 25 - 200 lakhs - ₹25,000	
	Benefit shall be payable only after 10 days of hospitalization						

	Standard	Advantage	Edge	Elite	Absolute	360	Total
Home Nursing Benefit	Optional Cover		This is a base cover under these plan options			Optional Cover	
	Upto ₹3,000 per day for a maximum of 15 days after completion of number of days under under post hospitalisation cover for the medical services of a nurse at your residence						
Daily Cash for Accompanying Insured Child	**Optional Cover:** ₹ 500 per day		₹ 1,000 per day	₹ 1,500 per day	₹ 2,000 per day	**Optional Cover:** 2 - 20 lakhs - ₹ 1,000 per day 25 - 200 lakhs - ₹ 2,000 per day	
	Benefit shall be payable for a maximum of 10 days subject to minimum of 3 days of hospitalization is required						
Compassionate Visit	**Optional Cover:** Upto ₹ 20,000				Upto ₹ 20,000	**Optional Cover:** Upto ₹ 20,000	

	Standard	Advantage	Edge	Elite	Absolute	360	Total
Maternity Benefit* (with 3 year waiting period)	Not Available		**Optional Cover:** Upto ₹ 25,000 for Normal and 35,000 Cesarean	**Optional Cover:** Upto ₹ 50,000 for Normal and Cesarean	Upto INR ₹ 50,000 for Normal and Cesarean	**Optional Cover:** 5 lacs - 20 lacs - Upto ₹ 25,000 for Normal and 35,000 Cesarean 25 lacs - 200 lacs - Upto ₹ 50,000 Normal and Cesarean	
New Born Baby Cover* (with 3 year waiting period)			**Optional Cover:** Within Maternity Benefit Sum Insured		Within Maternity Benefit Sum Insured	**Optional Cover:** Within Maternity Benefit Sum Insured	
Vaccination Expenses* (with 3 year waiting period)			**Optional Cover:** Upto INR 5,000	**Optional Cover:** Upto INR 7,500	Upto INR 10,000	**Optional Cover:** 5 lacs - 20 lacs - Upto INR 5,000 25 lacs - 200 lacs - Upto INR 10,000	
Air Ambulance Cover			**Optional Cover:** Upto 10% of Base Health Sum Insured and subject to a maximum of 5 lacs	Upto 10% of Base Health Sum Insured and subject to a maximum of 5 lacs		**Optional Cover:** Upto 10% of Base Health Sum Insured and subject to a maximum of 5 lacs	

	Standard	Advantage	Edge	Elite	Absolute	360	Total
Critical Illness Cover (Available for Age =>18 yrs)	**Optional Cover:** Additional Sum Insured equivalent to Base Health Sum Insured		**Optional Cover:** Additional Sum Insured equivalent to Base Health Sum Insured and subject to a maximum of 10 lacs				
Personal Accident Cover	**Optional Cover:** Additional Sum Insured equivalent to Base Health Sum Insured				**Optional Cover:** Additional Sum Insured equivalent to Base Health Sum Insured and subject to a maximum of 25 lacs		
Cap on Room Rent	**Optional Cover:** 1% of Base Health Sum Insured in case of stay in Non ICU; 2% of Base Health Sum Insured in case of stay in ICU	**Optional Cover:** Applicable for SI of 3/ 4/ 5 lacs): 1% of Base Health Sum Insured in case of stay in Non ICU; 2% of Base Health Sum Insured in case of stay in ICU	Not Available			**Optional Cover:** (Applicable for Sum Insured 2/ 3/ 4/ 5 lacs): 1% of Base Health Sum Insured in case of stay in Non ICU; 2% of Base Health Sum Insured in case of stay in ICU	
Individual/ Floater	Individual	Individual/ Family Floater				2 lacs - Individual 3 lacs and above - Individual/ Family Floater	
Waiting period for Pre Existing Disease	48 months for all age groups (Option of 36 months to be provided)			36 months for all age groups (Option of 24 months to be provided)		48 months for all age groups Option of 36 months/ 24 months to be provided	
Instalment Facility	Available						

* The policyholder needs to opt for Maternity Benefit/ New Born Baby Cover/ Vaccination Expenses together.

2.b. iv. What are covered under Optional Benefits?

Hospital Daily Cash

Hospital Daily Cash shall be payable for each and every completed day of the Insured Person's hospitalization during the policy period based on the Health Plan Option chosen by you, as mentioned in Section 2.b.iii. The benefit shall be payable only if the claim for in-patient treatment has been accepted and the Insured Person has been hospitalized for at least 3 consecutive days. The maximum benefit shall be restricted to a maximum of 10 days during a policyyear.

Further, this benefit is applicable on an individual basis irrespective of type of Health Cover (Individual/ Floater) and the benefit pay-out is over and above the Base Health Sum Insured. For more details, kindly refer to Health Policy Document.

Convalescence Benefit

A lump sum benefit shall be payable in case the Insured Person has been hospitalized for a minimum period of 10 consecutive days, as per the Health Plan Option chosen, as mentioned in Section 2.b.iii.

The benefit shall be payable only if the claim for in-patient treatment has been accepted and benefit shall be payable only once during the policy year. Further, this benefit is applicable on an individual basis irrespective of type of health cover (Individual/ Floater) and the benefit pay-out is over and above the Base Health Sum Insured. For more details, kindly refer to Health Policy Document.

Home Nursing Benefit

The expenses incurred for medical care services of a qualified nurse at the residence of the Insured Person following discharge from hospital after treatment for Illness/ Injury shall be payable only for a maximum of 15 days during the policy year after the completion of the number of days mentioned in the post-hospitalization medical expenses cover. The benefit shall be payable as per the Health Plan Option chosen, as mentioned in Section 2.b.iii.

Additionally, the benefit shall only be payable in case the claim for In-patient Treatment in respect of the same hospitalisation has been accepted by us and such medical care services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to Illness/ Injury for which the Insured Person has undertaken treatment during the hospitalisation

In case of individual policy, this benefit shall be available on individual basis and in case of family floater policy the benefit shall be available on floater basis. The payment under this benefit is within the Base Health Sum Insured. For more details, kindly refer to Health Policy Document.

Daily Cash for Accompanying an Insured Child

Daily Cash Benefit shall be payable for each and every completed day of the Insured Person's hospitalization during the policy period, for a maximum period of 10 days in a policy year and the amount payable shall vary based on the Health Plan Option chosen by you. Additionally, this benefit shall only be applicable provided that:

- Claim for in-patient treatment has been accepted by us
- Insured Person being hospitalized is a child aged 12 years or below

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater). The payment under this benefit is over and above the Base Health Sum Insured. For more details, kindly refer to Health Policy Document.

Compassionate Visit

Under this benefit, the costs of a return journey undertaken by air/ rail/ road (to and fro) up to the limit specified in Section 2.b.iii shall be payable for one of the Insured Person's spouse or children or parents to travel from the place of their residence to the hospital where the Insured Person is hospitalized. This benefit is only applicable in case hospitalization of the Insured Person extends beyond 5 consecutive days and the claim for in-patient treatment or day care treatment has been accepted by us.

In case of individual policy, this benefit shall be available on individual basis and in case of family floater policy the benefit shall be available on floater basis. The payment under this benefit is over and above the Base Health Sum Insured. For more details, kindly refer to Health Policy Document.

Maternity Benefit

The medical expenses incurred up to the Maternity Benefit Sum Insured specified in Section 2.b.iii. shall be payable for the delivery of the Insured Person's child (including caesarean section) or the medically necessary and lawful medical termination of pregnancy during the policy period provided the treatment is taken as an In-patient in a hospital and Insured Person has been continuously covered for at least 36 months under this benefit subject to the portability & continuity benefits as applicable. The benefit shall be payable subject to the following conditions:

- The benefit shall be payable for a maximum of 2 events of deliveries across all policy periods with us
- Pre-natal and post-natal expenses are covered up to the amount specified in the Section 2.b.iii
- Claim for delivery/termination under this benefit has been accepted by us
- Ectopic pregnancy shall not be covered under this Benefit, but any Claims will be considered under In-patient Treatment;

Further, this benefit is applicable on an individual basis irrespective of type of health cover (Individual/ Floater) and the benefit pay-out is over and above the Base Health Sum Insured. For more details, kindly refer to Health Policy Document.

New Born Baby Cover

The medical expenses incurred on the hospitalization of the Insured Person's new born baby during the policy shall be payable within the limits of the Maternity Sum Insured provided the claim for Maternity Benefit has been accepted under the Health Cover. You may cover the new born baby beyond 90 days on payment of requisite premium by way of an endorsement or at the next Renewal, whichever is earlier.

Further, this benefit is applicable on an individual basis irrespective of type of health cover (Individual/ Floater) and the benefit pay-out is over and above the Base Health Sum Insured. Any pre and post hospitalization expenses for the new born shall not be covered under this benefit. For more details, kindly refer to Health Policy Document.

Vaccination Expenses

The vaccination expenses incurred on the Insured Person's baby during the policy period shall be payable up to the limit specified in Section 2.b.iii. provided the claim for Maternity Benefit has been accepted by Us under the Health Cover and the Insured Person's maternity claim has been accepted, continues to renew the policy subsequently.

Further,

- The expenses will be covered from the birth till the baby completes two years
- Reimbursement claims for vaccination expenses can be submitted once during a policy year.
- The payment under this benefit is over and above the Base Health Sum Insured.

The cover under Maternity Benefit, New Born Baby Cover and Vaccinations Expenses are not available on a standalone basis and need to be availed in conjunction only. For more details, please refer to Health Policy Document.

Air Ambulance Cover

The expenses incurred by you for ambulance transportation in an airplane or helicopter for emergency life threatening health conditions which require immediate and rapid ambulance transportation from the site of first occurrence of the Illness /Accident to the nearest hospital shall be payable as specified in Section 2.b.iii. provided that:

- Claim for In-patient Treatment or Day Care Treatment under Health Cover and the Air Ambulance service relates to the same Illness / medical condition has been accepted by Us
- The necessity of the use of the Air Ambulance is certified by the treating Medical Practitioner;

The benefit shall also be payable if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better hospital facility due to lack of available/adequate treatment facilities.

Further, in case of individual policy, this benefit shall be available on individual basis and in case of family floater policy the benefit shall be available on floater basis. The payment under this benefit is within the Base Health Sum Insured. For more details, kindly refer to Health Policy Document.

Critical Illness Cover

If the Insured Person is diagnosed with any of the following Critical Illnesses during the policy period, the sum insured as specified in Section 2.b.iii. shall be payable. This benefit shall be applicable for each individual covered (aged 18 years or more) under the Health Cover, on payment of additional premium. In case you have opted for "Kotak Critical Illness Plus Benefit Rider", you cannot choose this benefit under Health Cover.

First diagnosis of the below-mentioned Illnesses	Undergoing for the first time of the following surgical procedures	Occurrence for the first time of the following medical events
Cancer of specified severity	Major Organ / Bone Marrow Transplant;	Coma of Specified Severity
Kidney failure requiring regular dialysis;	Open heart replacement or repair of heart valves	Stroke resulting in permanent symptoms;
Multiple Sclerosis with persisting symptoms;	Open chest CABG	Permanent Paralysis of Limbs;
Motor Neurone Disease with Permanent Symptoms	Aorta Graft Surgery	Myocardial Infarction (First Heart Attack of specified severity)
Benign Brain Tumor		Third Degree Burns
Primary (Idiopathic) Pulmonary Hypertension		Deafness, Loss of Speech
End Stage Liver Failure		

There is a waiting period of 90 days from the commencement of the first policy period. During this period, no benefit shall be payable in the event of diagnosis of any critical illnesses under this cover. Also, no benefit shall be payable under this cover in case any of the critical illnesses is a consequence of or arises out of any Pre-Existing Condition(s)/ Disease.

This benefit shall be payable only once in respect of any Insured Person across all policy period. Once a claim has been accepted and paid for any of the listed Critical Illnesses, this benefit shall cease in respect of that Insured Person, but shall continue to be in force for others (if any). In the event of a claim arising under this cover, you shall provide a written notice of the claim within 30 days from the date of the first diagnosis of the Critical Illness along with the documentation as specified in the Health Policy Document.

Further, this benefit is applicable on an individual basis irrespective of type of health cover (Individual/ Floater) and shall be available for any Insured Person aged 18 years or above. The payment under this benefit is over and above the Base Health Sum Insured and will not impact the Base Health Sum Insured or the Cumulative Bonus (if any). For more details, kindly refer to Health Policy Document.

Personal Accident Cover

This is an optional cover and shall be applicable for each Insured Person covered under Health Cover on payment of additional premium. The maximum benefit payable shall be equal to the Base Health Sum Insured subject to a maximum of 25 lakhs based on the Health Plan Option chosen by you. This benefit shall be payable only once in respect of any Insured Person across all policy periods. In case the Proposer has opted for “Life Plus Option” or “Kotak Permanent Disability Benefit Rider” under Life Cover, this benefit shall not be available under Health Cover. Further, this benefit is applicable on an individual basis irrespective of type of health cover (Individual/ Floater) and the payment under this benefit is over and above the Base Health Sum Insured and will not impact the Base Health Sum Insured or the Cumulative Bonus (if any). For more details, kindly refer to Health Policy Document. In the event where the Proposer have selected

- **Accidental Death**

  In the event of the unfortunate demise of the Insured Person, solely and directly due to an injury sustained in an Accident which occurs during the policy period, the Sum Insured under this benefit shall be payable based on the Health Plan Option chosen by you, as mentioned in Section 2.b.iii. The benefit shall only be payable, if the Insured Person passes away within 12 months from the date of that Accident. Once a claim has been accepted and paid under this benefit then this policy will automatically terminate in respect of that Insured Person only.

- **Permanent Total Disablement (PTD)**

  In the event, where the Insured Person becomes totally and permanently disabled as mentioned below, solely and directly due to an Accident which occurs during the policy period, the Sum Insured under this benefit shall be payable upto the limit specified in the Health Policy Document. The benefit shall only be applicable provided that the Permanent Total Disablement occurs within 12 months from the date of that Accident:

  - Loss of Use of both eyes, or Physical Separation/ Loss of Use of two entire hands or two entire feet, or one entire hand and one entire foot, or of such Loss of Use of one eye and such Physical Separation/ Loss of Use of one entire hand or one entire foot
  - Physical Separation/ Loss of Use of two hands or two feet, or of one hand and one foot, or of Loss of Use of one eye and Loss of Use of one hand or one foot
  - If such Injury shall as a direct consequence thereof, permanently, and totally, disable the Insured Person from engaging in any employment or occupation of any description whatsoever

  Once a claim has been accepted and paid under this benefit then the Personal Accident Cover will automatically terminate for the Insured Person only.

Cap on Room Rent

Under this benefit, the Room Rent payable shall be restricted to rateable proportion of the associated medical expenses incurred in the proportion of the difference between the eligible Room Rent and the Room Rent actually incurred, provided that reasonable and customary costs incurred on medicines/pharmacy, medical consumables, medical implants and diagnostic costs will be reimbursed based on the actual amounts incurred. In case you wish to choose this cover, you are entitled for a discount in the premium.

Proportionate deductions will not be applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category. Further, proportionate deductions will not be applied in respect of ICU Charges.

In case this cover is not opted for, the Insured Person will get the eligible Room Rent and associated medical expenses subject to Base Health Sum Insured including Cumulative Bonus and Restoration Benefit, if applicable.

2.b.v. Wellness Benefits under Health Cover:

	Standard	Advantage	Edge	Elite	Absolute	360	Total
Annual Health Check-up	For each Insured Person above 18 years of Age, each Policy Year for specified tests						
Second E-Opinion Cover	Not Available	Available					
Health and Rewards	Not Available	Available					
Value Added Benefits	Not Available	VA1	VA2	VA2	VA3	2 - 7.5 lacs - VA1; 10 - 20 lacs - VA2; 25 - 200 lac - VA3	Not Available

2.b.vi. What are covered under Wellness Benefits?

Annual Health Check Up

Any Insured Person covered under Health Cover and is aged 18 years or more, shall be entitled to one free health check-up at our network provider for each policy year for the specified tests. Annual Health Check-up shall not impact the Base Health Sum Insured or the Cumulative Bonus. This will be offered regardless of any claim admitted/ registered under the Policy. The health check-up will consist of the following tests for all eligible Insured Person; however, these tests are subject to revision at our discretion and will be communicated to Insured Person.

a) CBC; b) MER; c) Serum Cholesterol; d) Serum Creatinine;
e) SGPT /SGOT; f) ECG; g) Random Blood Sugar

Second E-Opinion Cover

The Insured Person is eligible to avail Second E-Opinion on his/ her medical condition occurring during the policy period. Insured Person shall be provided access to an E-opinion; however this shall not be deemed to substitute the their visit or consultation to an independent Medical Practitioner. The Insured Person is free to choose whether or not to obtain the expert opinion and if obtained whether or not to act on it. For more details, kindly refer to the Health Policy Document

Health and Rewards

Under this benefit, the Insured Person shall receive incentives for taking care of his/her health/fitness through regular preventative and wellness habits. You can earn reward points for the activities mentioned below. The activities may attract additional charges (decided at our discretion) to be directly payable by You. The activities undertaken by You will be rewarded in the form of reward points as per the terms and conditions mentioned below. You can redeem these reward points in accordance with the redemption terms and conditions.

- ### Health Risk Assessment (HRA)

  Health Risk Assessment questionnaire is used as a tool for evaluation of health and quality of life. It helps you to understand your lifestyle and its impact on your health status. The HRA will be an online assessment provided through vendor tie-ups. This can be undertaken only once per Insured Person in a policy year. You can earn 250 reward points on completion of HRA per Insured Person, in case of individual policy and maximum up to 500 reward points per family in case of Floater Policy in a Policy Year. Any Insured Person aged above 18 years will be eligible to undergo HRA. For more details, kindly refer to the Health Policy Document

- ### Health Check-up

  You will also be provided reward points for undergoing the Health Check-Up as specified under Section 2.b.vi.1. We will facilitate in booking the appointment and arrange for the check-up through any of our Network Providers. You can earn 500 reward points for undergoing Health Check-Up per Insured Person in case of individual policy and a maximum of 1,500 reward points per family in case of floater policy in a policy year. If the result of all the medical test parameters is within normal limit/ range, additional 500 reward points per Insured Person in case of individual policy and a maximum of 1,500 reward points per family in case of floater policy will be awarded in a policy year. For more details, kindly refer to the Health Policy Document

Preventive Check-up

You can also earn reward points by undergoing certain other diagnostic and preventive health check-up at any diagnostic centre at your own expenses. You shall have to submit medical reports of these tests to us. List of the Tests eligible under this are mentioned below:

Name of the Test	Applicability
Heart related screening tests (2D echo/ TMT/ ECG)	Individual above the age of 45 years
HbA1c / Complete lipid profile	Any age
PAP Smear/ Mammogram/ CA-125	Females above the age of 40 years
Prostate Specific Antigen (PSA)	Males above the age of 45 years
Vitamin Profile test (D3, B12 and TSH)	Any age
USG whole abdomen	Any age
Kidney Function test	Any age
Renal function test	Any age
Cardiac biomarker test	Any age
Body Fat Analysis	Any age

You can earn 250 reward points for undergoing preventive check-up per test per Insured Person in case of individual policy and a maximum of 1,500 reward points per family in case of floater policy in a policy year. If the result of the medical test parameters mentioned above are within normal limits/ range, additional 250 reward points per test per Insured Person in case of individual policy and a maximum of 1,500 reward points per family in case of floater policy will be awarded in a policy year. One test will be considered only once for reward points during a Policy Year.

Fitness Initiatives

You will be rewarded, if you undertake any one or more of the following fitness & health related activities as given below which are undertaken after Policy Start Date.

Fitness Activities	Reward Points
Participation in Professional sporting events like Marathon/ Swimathon/Triathlon, etc.	500 points per event and 1000 points per Policy Year
Gym/ Yoga membership for 1 year	1,000 per Policy Year
Sports Activity membership (Swimming/ Tennis/ Badminton/ for 1 year	1,000 per Policy Year
Share your Fitness story	250 per Policy Year
Winning Health Quiz/ Contests organized by us	250 per event and 500 points per Policy Year

- **Terms for Reward Point Accumulation under Health and Rewards:**

  You can earn a maximum of 5,000 reward points per Insured Person in case of individual policy and a maximum of 10,000 reward points per family in case of floater policy in a policy year.You should notify and submit relevant documents, bills etc. for various wellness activities within sixty (60) days of undertaking such activity.

- **Redemption of Reward Points**

  Each Reward Point will be equivalent to 0.25 Rupees. You can redeem these Reward points (after conversion to the equivalent rupee amount) against any of the following options:

  - Outpatient medical expenses like consultation charges, medicine & drugs, dental expenses, wellness & preventive care and other miscellaneous charges
  - Diagnostic expenses and health check-ups through our Network providers.
  - In-patient Treatment and Day Care Treatment claims, provided that the Base Health Sum Insured, Cumulative Bonus and Restoration Sum Insured (if applicable) are exhausted during the policy year.
  - Payment of Co-payment, if applicable
  - Non-medical expenses listed under Annexure III of Health Policy Document

Terms for Redemption

- Reward points not redeemed in the given policy year can be carried forward for a maximum up to 1 year from the date of expiry of the policy year in which they are earned.
- Reward Points shall automatically lapse upon cancellation of the Health Cover. However, any unclaimed and accrued points (from previous policy year/ month) shall be available for redemption up to 1 year from the date of cancellation of the Health Cover unless the same has been cancelled by us on grounds of misrepresentation, fraud, nondisclosure or non-cooperation of the Insured.
- Reward Points cannot be redeemed for the same activity against which the Reward points were earned at first.
- For e.g. If reward points are earned for undergoing "Preventive Check-up – HbA1c/ Lipid Profile" then the same points cannot be used for claiming under the diagnostic expenses for undergoing the said test.
- Redemption of the rewards points can be done twice during a policy year.
- Redemption of rewards points does not entail any cash benefit to be provided to You.

Value Added Benefits

The benefits listed below are Value Added Benefits and shall be available to the all the Insured Persons covered under the Health Cover. Benefits under this Section are subject to the terms, conditions and exclusions of this Health Cover. The activities may attract additional charges (decided at our discretion) to be payable by You directly to the vendor. Any claim under this Section will not impact the Base Health Sum Insured or the eligibility for Cumulative Bonus.

VA1	VA2	VA3
Online customer profile	Online customer profile	Online customer profile
Doctor directory	Doctor directory	Doctor directory
Doctor appointment	Doctor appointment	Doctor appointment
Online Pharmacy/ Online Diagnostics tests booking	Online Pharmacy/ Online Diagnostics tests booking	Online Pharmacy/ Online Diagnostics tests booking
Health tips/ articles	Health tips/ articles	Health tips/ articles
Home Health	Home Health	Home Health
	E-consultation	E-consultation
		Dietician/ Nutritionist opinion

- **Online customer profile**

  Based on the Health Risk Assessment taken and health check-ups, if any, undertaken by any of the Insured Person, an online customer profile through our vendor tie-up will be maintained by us which can be accessed by the Insured Person to review Health status.

- **Doctor directory**

  You will be provided with online platform through our vendor tie-up for providing access to information on general physicians, specialists and super specialists.

- **Doctor appointment**

  You will be provided with online platform through vendor tie-ups for fixing up doctor appointments for the Insured Person(s).

- **Online Pharmacy, Diagnostic tests and other Health/ Wellness Offering**

  We will facilitate the Insured Person for various offerings on health and wellness services like Diagnostic Centres, Pharmacy, Gymnasiums, Yoga, etc. through the Network Providers/ vendor tie-ups.

- **Health tips/ articles**

  We will provide information on various health related applications, wellness training, maintaining fitness and good health, information on various diseases, dietary plans, etc. through periodic communications and through online platform.

- **Home Health**

  We will provide through vendor tie-ups, Home Health services like physiotherapy, nursing care, trained attendants and medical equipment's, for the Insured Person.

- **E-consultations**

  We will provide with or arrange for an online platform through vendor tie-ups for providing with E-consultations to the Insured Person.

- **Dietician & Nutritionist opinion**

  We will arrange for dieticians/ nutritionists through our vendor tie-ups to provide for counselling to the Insured Person.

3 Eligibility Criteria

Eligibility Criteria	Life Cover	Health Cover
Entry Age (as on last birthday)	Minimum: 18 years Maximum: 65 years	Minimum: 18 years (adult); 91 days (child) Maximum: 65 years (adult); 25 years (child)
Maturity Age (as on last birthday) Exit Age (Health Cover)	Minimum: 23 years Maximum: 70 years	There is no exit age. Lifelong Renewal shall be allowed under Health Cover
Policy Term / Policy Period	Minimum: 5 years Maximum: 30 years	1 / 2 / 3 years
Premium Payment Term (PPT)	Single Pay: Onetime payment Regular Pay: Equal to Policy Term	• 1-year policy term - the premium paying term would be 1 year • Policy Term of 2/3 years - Single Premium.
Premium Payment Option	Single & Regular Pay	• Half yearly, Quarterly, Monthly (if instalment option is chosen under 1-year policy term) • Single (in case of no instalment facility)
Modal Factor (% of yearly premium)	The following modal loadings shall be used to calculate the instalment premium in case of Regular Premium Payment Options: Yearly 100% Half-yearly 51% Quarterly 26% Monthly 8.8%	Instalment Facility (applicable for 1yr policies) Monthly Premium loading – 10% Quarterly premium loading – 7.5% Semi Annual Premium Loading – 4%
Premium	Based on Sum Insured, Policy Term, Gender & Premium Payment Option	Based on Sum Insured, Policy Term, Age, Zone, Optional Covers, Policy Type, Premium Payment Option, Loading/ Discounting.
Sum Insured	**Sum Insured:** Minimum: ₹ 3,00,000 Maximum: ₹ 24,99,999	**Base Sum Insured:** Minimum: ₹ 2,00,000 Maximum: ₹ 2,00,00,000

Eligibility Criteria	Life Cover	Health Cover
Policy Type	Individual	Individual / Family Floater Policy
Relationships Covered	Individual	Individual Policy – Self Family Floater – Maximum of 2 Adults & 3 Children
		Relationships covered: Self, Your legally married spouse, Your natural or adopted dependent children, Your parents, Your parents-in-law and Your siblings, Employer-Employee. Natural/ Appointed Guardian can also take insurance for minor under their guardianship
[1]Combi Discount	**Life Cover:** 5% Discount shall be applicable only on 1st Year for Regular paying policies **Health Cover:** 5% Discount shall be applicable on 1st Year as well as on renewal where both Life & Health Covers are renewed together	

Terms and Conditions for Life Cover

1. **Death Benefit:**

   In case of unfortunate event of the death of the Proposer during the Grace Period, the Sum Insured less the premium due at the time of death, shall be payable to the beneficiary. In addition, for non-annual Premium Payment Modes, balance of the Premiums (if any) payable in the policy year of death shall be deducted.

2. **Riders:**

   The payment of Rider premium shall be made in addition to the premium for the Base Plan and collected along with the premiums for the Base Plan. Premium payment type (Regular / Single) and premium payment mode of the rider should be same as that of Base Plan. For more details on the Rider, please refer to the rider brochure.

3. **Lapse:**

   If during the policy term, any premiums due are not paid within the grace period, the policy together with the rider benefits, if any, shall lapse from the date of the first unpaid premium and the life cover shall cease.

4. **Reduced Paid-up:**

   - Regular premium paying policy shall not be eligible for Reduced Paid Up.
   - Single premium paying policy shall become fully Paid-Up after payment of premium

5. **Policy Revival:**

   A lapsed policy can be reinstated (with or without Riders) for full benefits on revival within five years from the date of first unpaid premium.

   You can revive the policy without evidence of good health on payment of the outstanding premiums with interest charge (currently 9% p.a. of outstanding premiums), if the payment is made within six months from the date of first unpaid premium. Thereafter to revive the policy, evidence of good health would be required along with payment of the outstanding premiums along with interest charge (currently 9% p.a. of outstanding premiums).

   All benefits under the policy shall be reinstated on the revival of the policy. Revival of the policy shall be based on Underwriting Policy of the Company.

   If a lapsed policy is not revived during the revival period, the policy shall be terminated without paying any benefits.

6. **Surrender:**

   Surrender Value shall be acquired under Single Premium policies once the premium has been received. In case you wish to surrender, the, Surrender Value payable shall be based as per the table given below:

   75% x Single Premium Paid x (1- 1/ Policy term) x (Outstanding Policy Term/Policy Term)

   There is no surrender value applicable under Health Cover.

7. Suicide Exclusion:

In the event of the Life Insured committing suicide within 12 months from the Date of Commencement of the risk of the Policy or from Date of Revival of the policy, 80% of the Total Premiums paid till date of death shall be payable to the nominee/beneficiary.

In case of suicide after 12 months from the Date of Commencement of the risk of the policy, following shall be applicable:

- In case of suicide within one year of the date of revival of the policy when the revival is done within 6 months from the date of first unpaid premium, Suicide Exclusion shall not be applicable and the Death Benefit under the product shall be payable.
- However, in case of suicide within 1 year of the date of revival, when the revival is done after 6 months from the date of first unpaid premium, the benefit payable shall be higher of 80% of Total Premiums Paid till date of death or Surrender Value (if any) as at on the date of death provided the policy is in-force.

Terms and Conditions for Health Cover

8. Waiting Period:

No benefit shall be payable under Health Cover in case the claim arises directly or indirectly for/ caused by/ based upon/ arising out of or howsoever attributable to any of the exclusions listed below. All waiting periods will apply individually to each Insured Person:

a) Pre-Existing Diseases Waiting Period (Code – Excl01)

Pre-existing disease (if any) shall be covered only after waiting period of continuous coverage has elapsed for the Insured Person, since the inception of the Health Cover as specified below. The waiting period applicable shall vary based on the Plan Option chosen by you under Health Cover.

Plan Option	Pre-Existing Disease Waiting Period
Standard, Advantage, Edge, 360, Total	48 months
Elite, Absolute	36 months

The above waiting period can be reduced upto 36 months/ 24 months depending on the Plan opted for on the payment on additional premium. This waiting period will be reduced to the extent of the prior coverage if the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations.

b) 30 Day Waiting Period (Code – Excl03)

Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c) Specified disease/ procedure waiting period (Code – Excl02)

Any Medical Expenses incurred on the treatment of any of the following listed conditions/ surgeries/ treatments shall not be covered until the expiry of 24 months of continuous coverage from inception of Health Cover or date of the Insured Person being included under the Health Cover, whichever is later:

Cataract;	Stones in the urinary and biliary systems;
Benign Prostatic Hypertrophy;	Dilatation and curettage, Endometriosis;
Myomectomy, Hysterectomy unless because of malignancy;	All types of skin and internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant;
All types of Hernia, Hydrocele;	Dialysis required for chronic renal failure;
Fissures and/or Fistula in anus, haemorrhoids/piles;	Tonsillitis, adenoids and sinuses;
Arthritis, gout, rheumatism and spinal disorders;	Gastric and duodenal erosions and ulcers;
Joint replacements unless due to Accident;	Deviated nasal septum;
Sinusitis and related disorders;	Varicose Veins/ Varicose Ulcers.

*The maximum benefit payable for an Insured Person's cataract treatment shall be 10% of the Base Sum Insured up to a maximum of ₹ 100,000 per eye for each policy year of the Policy Period.

If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.

If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

d) Maternity Benefit Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section will not be covered until 36 months of continuous coverage has elapsed for that particular Insured Person since the inception of the Maternity Expenses Benefit under the Policy for that Insured Person. This waiting period will be reduced by number of continuous preceding years of Maternity coverage of the Insured Person under previous health insurance policy by us or any other health insurance plan with an Indian non-life insurer/ health insurer as per guidelines on portability issued by the insurance regulator.

9. Additional Discounts:

You are eligible to get additional discount under Health Cover along with "Combi Discount"

Discount (applicable on Health Premium)	
Long Term Discount	2 years policy period - 2.5% 3 years policy period - 5%
Online Policy Issuance	2.5%
Kotak Group Employee Discount	5%
Family Discount (not applicable for floater policies)	2 eligible members - 2.5% More than 2 members - 5%
Cross Sell Discount (if the policyholder has one active policy with Kotak Mahindra General Insurance Company Ltd)	10%

10. Loading:

In case you wish to pay the premium through instalments or wish to reduce the waiting period for pre-existing diseases, the Company shall increase the premium by a specified percentage as mentioned below:

Loading (applicable on Health Premium)	
Instalment facility (Applicable for one year policies)	• Monthly Premium - 10.00% • Quarterly Premium - 7.50% • Semi Annual Premium - 4.00%
Pre-Existing Disease Waiting Period	• Reducing the waiting period from 48 to 36 months: 7% • Reducing the waiting period from 48 to 24 months: 20% • Reducing the waiting period from 36 to 24 months: 12.15%

Permanent Exclusions

No benefit shall be payable under any circumstances for any claim in connection with or with regard to any of the following permanent exclusions as specified below:

Standard Exclusions

- **Investigation & Evaluation (Code- Excl04)**
  a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
  b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded
- **Rest Cure, rehabilitation and respite care (Code – Excl05)**
  c) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
    i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
    ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
- **Obesity/ Weight Control (Code – Excl06)**
  Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
  1) Surgery to be conducted is upon the advice of the Doctor
  2) The surgery/Procedure conducted should be supported by clinical protocols
  3) The member has to be 18 years of age or older and
  4) Body Mass Index (BMI);
    a) greater than or equal to 40 or
    b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type 2 Diabetes

- **Change-of- Gender treatments (Code – Excl07)**
  Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

- **Cosmetic or plastic Surgery (Code – Excl08)**
  Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

- **Hazardous or Adventure sports: (Code- Excl09)**
  Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

- **Breach of law (Code – Excl10)**
  Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

- **Excluded Providers: (Code- Excl11)**
  Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

- **Code- Excl12**
  Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

- **Code- Excl13**
  Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

- **Code- Excl14**
  Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.

- **Refractive Error (Code- Excl15)**
  Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
- **Unproven Treatments (Code – Excl16)**
  Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
- **Sterility and Infertility (Code- Excl17)**

  Expenses related to sterility and infertility. This includes:

  i. Any type of contraception, sterilization

  ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

  iii. Gestational Surrogacy

  iv. Reversal of sterilization
- **Maternity (Code- Excl18)**
  i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy

  ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

Specific Exclusions

- Costs of routine medical, eye or ear examinations preventive health check-ups, spectacles, laser surgery for correction of refractory errors, contact lenses, hearing aids, dentures or artificial teeth;
- Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;
- Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services, medical supplies including elastic stockings, diabetic test strips, and similar products.
- Expenses incurred on all dental treatment unless necessitated due to an Accident and treatment is taken in in-patient department of hospital or day care centre;
- Acupressure, acupuncture, magnetic and such other therapies;

- Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;
- Vaccination or inoculation of any kind, unless it is post animal bite and there is hospitalisation as an in-patient;
- Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)
- Treatment relating to Congenital external Anomalies;
- Any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition;
- Costs incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose;
- Any treatment taken outside India;
- Any treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council;
- Any consequential or indirect loss arising out of or related to Hospitalization;
- Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority;
- Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;
- All non-medical expenses listed in Annexure III (List I) of the Policy.
- Any OPD treatment will not be covered
- Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.
- Treatment such as External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), and Hyperbaric Oxygen Therapy will not be covered unless it forms a part of In-Patient Treatment in case of hospitalisation or part of discharge advice upto the Post hospitalisation period as specified in the Policy Schedule.
- Any physical, medical condition or treatment that is specifically excluded in the Policy Schedule under Important Conditions

Claims Procedure

On the occurrence or discovery of any Illness or Injury that may give rise to a claim under this Policy, you can avail cashless facility only at our network provider or you may make the payment post which the eligible amount would be reimbursed. For more details on claims procedure, and documentation required kindly refer to the policy document

Health Rewards & Value Added Benefits

- Any information provided by You shall be kept confidential
- For services which are provided through empanelled medical experts/ centres/ service providers, we are only acting as a facilitator, hence we would not be liable for any incremental cost of the services.
- All medical services are being provided by empanelled medical experts/ centres/ service providers who are empanelled after full due diligence. Nonetheless, Insured Person may consult their personal doctor before availing the medical services. The decisions to utilise the services will solely be at the Insured Person's discretion.
- We/Company/Us or its group entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges and expenses which an Insured Person/ You may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
- This shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured person is free to choose whether or not to undergo the same and if done whether or not to act on it.
- We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

Cancellation

i. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

   For Policyholder's initiated cancellation, the Company would compute refund amount as pro-rata (for the unexpired duration) premium. This would further be deducted by 25% of computed refundable premium.

   Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer: IRDAI/HLT/REG/CIR/003/01/2020

Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration, kindly refer: IRDAI/HLT/REG/CIR/003/01/2020

Zone Classification:

Zone I: Mumbai (including Thane and Navi Mumbai) and Delhi (including NCR areas)

Zone II: Kolkata, Hyderabad, Chennai, Pune, Bangalore and Gujarat

Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

Identification of Zone will be based on the city of the Proposer. A Single Zone shall be applicable to all members covered under the Policy. You also have an option of selecting another Zone from the applicable Zones of any of the Insured Person(s) in the Policy. Option to select a Zone higher than that of the actual Zone is available on payment of relevant premium at the time of buying the Policy or at the time of Renewal. Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident.

Co Payment

- Persons paying Zone I premium can avail treatment all over India without any Co-payment
- Persons paying Zone II premium can avail treatment in Zone II and Zone III without any co-payment
- Persons paying Zone III premium can avail treatment in Zone III only without any co-payment

Co-payment for treatment in a Higher Zone

In case of treatment taken in a city, in a Zone higher than the eligible Zone for the Insured Person, the Co-payment percentages as below shall apply:

Applicable Zone	Treatment Taken at	Co-payment applicable
Zone II	Zone I	10%
Zone III	Zone I	20%
Zone III	Zone II	10%

For detailed information on Health Cover - Terms and Conditions, please refer to the Health Policy Document

General Terms and Conditions

Grace Period / Relaxation Period

- For Health Cover, at the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of atleast 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- For Life Cover - There is a grace / relaxation period of 30 days from the due date for payment of premium for the yearly, half-yearly and quarterly mode for premium payment in instalments and for the monthly mode there is a grace / relaxation period of 15 days
- For Health Cover - Grace Period of 15 days would be given to pay the instalment premium due for the policy.
- For Health Cover, during such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
- During this period the policy will be considered to be in-force with risk cover as per the terms of the policy
- For Life Cover, in case of death during the grace period, Sum Insured less the premium due at the time of death is payable.
- The Life Cover shall get lapsed and the Health Cover shall be terminated under this plan for other Life Insureds if any, in the event of non-receipt of premium within the grace / relaxation period

Free Look Period

The policyholder is offered 15 days' free look period for a policy sold through all channels (except in case of electronic policies and policies obtained through Distance Marketing* Mode which shall have 30 Days) from the date of receipt of the policy wherein the policyholder may choose to return the policy, stating the reasons thereof within 15 days / 30 days of receipt if s/he is not agreeable with any of the terms and conditions of the plan.

Should s/he choose to return the policy, s/he shall be entitled to a refund of the premium paid after adjustment for the expenses of medical examination if any, stamp duty and proportionate risk premium for the period of Life cover. A policy once returned shall not be revived, reinstated or restored at any point of time and a new proposal shall have to be made for a new policy. The free look period shall be applicable on the Combi Product as a whole.

*Distance Marketing includes every activity of solicitation (including lead generation) and sale of insurance products through the following modes: (i) Voice mode, which includes telephone calling (ii) Short Messaging service (SMS) (iii) Electronic mode which includes e-mail, internet and interactive television (DTH) (iv) Physical mode which includes direct postal mail and newspaper & magazine inserts and (v) Solicitation through any means of communication other than in person.

Nomination

Nomination shall be allowed under the plan as per the provisions of Section 39 of the Insurance Act, 1938 as amended from time to time. For more details kindly refer to the policy document as uploaded on **https://www.kotaklife.com**

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the Life Insured. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/ Endorsement(if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

Assignment

Assignment shall be allowed under this plan (except on the Health cover) as per the provisions of Section 38 of the Insurance Act, 1938 as amended from time to time. For more details kindly refer to the respective policy document as uploaded on **https://www.kotaklife.com**

Policy Issuance

Where the risk is not accepted by one of the Insurers, the Combi-Product(s) shall not be issued and the other Insurer shall be free to issue their respective policy individually provided that you shall not be entitled to the combi discount, if any, being offered under the Combi-Product(s) and would be governed by the terms and conditions of the individual policy being offered by either of the Insurer.

Mandatory Terms & Conditions applicable for Kotak Health Maximiser

- This Combi-Product is jointly offered by "Kotak Mahindra Life Insurance Company Limited" ("KLI") and "Kotak Mahindra General Insurance Company Ltd" ("KGI")
- The risks of this 'Combi Product', i.e., the life cover and the health cover, are distinct and are assumed / accepted by aforesaid respective insurance companies. Further, the liability to settle the claim for health insurance benefits shall vest with KGI and for life insurance benefits with KLI
- The legal/ quasi legal disputes, if any, are dealt by the respective insurers for respective benefits. For Life Cover, all the legal disputes will be handled by KLI and for health benefits all the legal disputes will be handled by KGI
- All requests impacting premium, claims or policy terms governing life cover or health cover may be received by either of the Insurers, but, shall be serviced by the respective insurer and the receiving Insurer shall only facilitate receipt of such requests
- The available premium payment options for Kotak Health Maximiser are Cheque, cash, demand draft, net banking, credit card/debit card, other online payment modes etc., in favour of either, Kotak Mahindra Life Insurance Company Limited OR Kotak Mahindra General Insurance Company Limited
- Both Insurers will fulfil servicing request received by them as mentioned in the respective policy contracts and in accordance with the provisions of Protection of Policyholders' Interests Regulations, 2017
- The policyholder is eligible, during the policy term, to continue with either the life cover or the health cover and discontinue the other. In such a case, the combi-discount shall not be available to the policyholder. The Premium Component applicable to both life cover and health cover is separate and the details are mentioned under the applicable policy contract
- Upon payment of death benefit to the beneficiary under life cover, the health cover may continue for other covered members as per the terms and conditions of the health cover
- "Kotak Health Maximiser" offers guaranteed renewability for the Health Cover and the policyholder is entitled for lifelong renewal
- For any claim or any policy related issues, the policyholder may contact Kotak Mahindra General Insurance Company Limited or Kotak Mahindra Life Insurance Company Limited at their Toll Free number: 1800 209 8800
- Family Health Plan Insurance TPA Ltd is the TPA for Kotak Mahindra General Insurance Company Limited for Health Insurance Claims
- Withdrawal of Tie Up / Combi Product(s): Either of the insurers may terminate the tie-up between them to offer Combi-Product, in whole or in part or may withdraw the Combi-Product only after making a joint application to the IRDAI for approval. Upon receipt of such approval from IRDAI, the insurers shall provide notice of 90 days to the Policyholder of such withdrawal of tie-up between the insurers or withdrawal of Combi-Product, as the case may be. However, termination of tie-up between the insurers shall not impact the discount (applicable on health cover only) and tenure of the policy and the same shall continue until the expiry or termination of the coverage in accordance with the terms and conditions of the respective policy cover. Each insurer shall continue to be responsible towards the benefits offered under the respective cover as per the applicable terms and conditions

- Upon termination of the arrangement between the insurers, each insurer shall continue to receive request for servicing the policy post termination of the arrangement
- The Policyholder may lodge a grievance with regards to either of the covers offered under this product at the branches of either of the Insurers. Complaint shall be routed to the respective insurer who shall then respond / address to the policyholder directly. The detailed information including the particulars of Ombudsman is mentioned under the grievance redressal mechanism section of the terms and conditions for both life and health cover
- The Policyholder is requested to read and familiarise himself/herself with the benefits and servicing structure of this Combi-Product before deciding to purchase the policy

Extract of Section 41 of the Insurance Act, 1938 as amended from time to time states:

(1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer:

(2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees

Extract of Section 45 of the Insurance Act, 1938 as amended from time to time states:

Fraud and Misstatement would be dealt with in accordance with provisions of Section 45 of the Insurance Act, 1938 as amended from time to time. Please visit our website for more details:

https://www.kotaklife.com/assets/images/uploads/why_kotak/section38_39_45_of_insurance_act_1938.pdf

About Us

Kotak Mahindra Life Insurance Company Ltd. is a 100% owned subsidiary of Kotak Mahindra Bank (Kotak) which provides world-class insurance products with high customer empathy. Its product suite leverages the combined prowess of protection and long term savings. Kotak Life Insurance is one of the growing insurance companies in India and has covered over several million lives.

For more information, please visit the company's website at **https://www.kotaklife.com**

Kotak Mahindra General Insurance Company Ltd.

A 100% subsidiary of Kotak Mahindra Bank Ltd., Kotak Mahindra General Insurance Company Ltd. (Kotak General Insurance) was established to service the growing non-life insurance segment in India. At Kotak General Insurance, we value customer service, quality and innovation above everything else. The company aims to cater to a wide range of customer segment & geographies offering an array of non-life insurance products like Motor, Health, Home, Fire & Burglary etc. As a practice, the company seeks to provide a differentiated value proposition through customized products & services leveraging state of art technology & digital infrastructure.

For more information, please visit the company's website at **www.kotakgeneral.com**

Kotak Mahindra Group

Kotak Mahindra Group is one of India's leading banking and financial services organizations, offering a wide range of financial services that encompass every sphere of life. From commercial banking, to stock broking, mutual funds, insurance and investment banking, the Group caters to the diverse financial needs of individuals and the corporate sector. For more information, please visit the company's website at **www.kotak.com**

BEWARE OF SPURIOUS PHONE CALLS AND FICTITIOUS/FRAUDULENT OFFERS

IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums.
Public receiving such phone calls are requested to lodge a police complaint.

kotak life

Hum hain... hamesha

Kotak Health Maximiser - UIN: KOTHLIP24026V012324 is a Combi Product with both protection & health benefits, where protection benefits are being offered by Kotak Mahindra Life Insurance Company Ltd under Kotak Term Plan - UIN 107N005V06, Form No. N005 and health benefits are being offered by Kotak Mahindra General Insurance Company Ltd under Kotak Health Premier – UIN KOTHLIP23109V042223; ARN : KGI/23-24/II/E-BC/2310.

The sales brochure gives only the salient features of the plan. For sub-standard lives, extra premium may be charged based on respective insurer's underwriting policy. For more details on riders please read the Rider Brochure. Please refer to the Policy Document for specific details on all terms and conditions. Please know the associated risk and applicable charges from your insurance agent or the intermediary or the policy document of the insurer.

Kotak Mahindra General Insurance Company Ltd.: Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai – 4000051. Maharashtra, India. CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152. Website: www.kotakgeneral.con I Email: care@kotak.com I Toll Free No: 1800 2666 4545.

Kotak Mahindra Life Insurance Company Limited.: Regn. No.: 107 CIN: U66030MH2000PLC128503, Regd. Office: 8th Floor, Plot # C- 12, G- Block, BKC, Bandra (E), Mumbai - 400 051. Website: www.kotaklife.com I WhatsApp: 9321003007 | Toll Free No:1800 209 8800.